

# One Step Forward, Two Steps Back: A Constitutional and Critical Look at Ohio's New Living Will Statute

## I. INTRODUCTION

Recent advances in health care now give doctors the ability to extend our lives long after our powers to appreciate it are dead and gone.<sup>1</sup> Through life support systems, including artificial nutrition and hydration, individuals can be kept alive indefinitely in hospital beds despite the fact they are unconscious and totally unaware of their surroundings. Such individuals would die naturally except for the machines that sustain them, but they are mechanically kept alive, suspended between life and death as many of us would normally define those terms.<sup>2</sup>

Although some think that the sanctity of life requires us to prolong it as long as we are technically able, others feel that this technology merely extends the pain of the victim's loved ones, preventing the patient from moving on into the next world and slowing the healing process of those left behind.<sup>3</sup> Thus, an inherent conflict is born when an individual is placed on life support systems between those who wish the systems removed and those who desire the patient to be artificially sustained.

These conflicts gave rise to a variety of case law and statutory law as the individual states began to wrestle with the problems of defining life and death. In order to handle these problems, many states passed statutes allowing individuals to make these decisions for themselves through advance directives, in case they become incapacitated in the future.<sup>4</sup> This, however, did not solve the problems in cases in which individuals became permanently unconscious without advance directives. Complicated issues arose as to what extent the state could prevent loved ones from terminating the life support systems, despite the fact that family members thought it was either in the patient's best interests or

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<sup>1</sup> Patients in a permanently vegetative state, or a PVS, which will be defined below, can survive five, ten, and even twenty years through life support systems. Ronald E. Cranford, M.D., *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, in HASTINGS CENTER REPORT, February/March 1988, at 27, 31.

<sup>2</sup> The plight of individuals in a PVS is discussed in detail in Part II of this Note, as is the issue of why PVS patients are not, at least by medical standards, "dead."

<sup>3</sup> See, e.g., *Matter of Storar*, 420 N.E.2d 64, cert. denied, 454 U.S. 858 (1981); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986).

<sup>4</sup> When Ohio enacted the laws recognizing living wills, it joined forty-one other states that had previously done so. M. Rose Gasner, *The Unconstitutional Treatment of Nancy Cruzan*, 7 N.Y.L. SCH. J. HUM. RTS. 1, 14-15 (1990).

would have been the individual's desires. This problem came to the forefront when the Supreme Court heard its first right to die case, *Cruzan v. Director, Missouri Department of Health*.<sup>5</sup>

Since that decision, the State of Ohio has enacted its own legislation concerning life support systems and the right of individuals to refrain from such treatment. This Note will analyze the Ohio statute in light of the *Cruzan* decision, and also question the wisdom of the statute given the medical and practical realities of individuals who are permanently unconscious. Part II of this Note will briefly examine the medical status of PVS patients.<sup>6</sup> Part III will look into the history behind the Ohio statute and summarize its most controversial provisions, the sections dealing with nondeclarants. Part IV will consider the *Cruzan* holding in some detail and decide what constitutional protections, if any, the Court established for an individual's right to die. Part V will then determine if the Ohio statute is constitutionally sound given the Supreme Court's holding in *Cruzan*. Finally, Part VI will then scrutinize the practical implications of Ohio's living will statute in light of modern popular and medical opinions.

## II. THE MEDICAL STATUS OF THE PERMANENTLY UNCONSCIOUS

Before plunging into any legal inquiries on what the law is or should be concerning the permanently unconscious, it should be obvious that one needs to understand exactly what "permanently unconscious" means from a medical perspective. To do this, it is helpful to distinguish between those that have suffered clinical "brain death," those in irreversible comas, and individuals in persistent vegetative states ("PVS"), or in other words, those who are permanently unconscious.<sup>7</sup>

The brain stem, located in the lower center of the brain, controls what may be considered our "lower" functions, such as respiration, reflexes, and pupillary response to light.<sup>8</sup> The cerebral hemispheres, or more specifically, the cerebral cortex located in the outer layers of the cerebral hemispheres, control what may be considered our higher functions, including consciousness, awareness, and other voluntary and involuntary actions.<sup>9</sup> When a person

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<sup>5</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

<sup>6</sup> PVS, or "persistent vegetative state," will be used interchangeably throughout the text with the term "permanently unconscious."

<sup>7</sup> Cranford, *supra* note 1, at 27-28.

<sup>8</sup> *Id.* at 27.

<sup>9</sup> *Id.*

suffers brain death, not only do the higher functions of the cerebral cortex cease, but all of the "lower" brain stem functions are lost as well, including the most primitive cough and gag reflexes and spontaneous respiration.<sup>10</sup> Some semi-autonomous functions not totally dependent on the brain stem, such as one's heartbeat, may continue despite the fact that the person is clinically brain dead.<sup>11</sup>

Patients in a PVS, on the other hand, generally have not suffered neurological damage to either the brain stem or the ascending reticular activating system, which is located in the brain stem and is responsible for arousing the entire brain.<sup>12</sup> This phenomenon occurs because the cerebral cortex suffers severe damage from lack of blood (ischemia) or lack of oxygen (hypoxia) much more quickly than the lower brain stem.<sup>13</sup> Thus, for example, a person who experiences either loss of blood or loss of oxygen to the brain for four to six minutes will likely suffer a complete loss of the cerebral cortex but not the brain stem.<sup>14</sup> The patient will then enter into a temporary coma, and then "awaken" into a PVS, from which there is no recovery.<sup>15</sup>

Patients in a PVS manifest a variety of deceiving symptoms that make them appear to be awake. For example, their eyes remain open, and they go through periods of being asleep or awake.<sup>16</sup> They also retain the protective gag and cough reflexes.<sup>17</sup> Further, they may make unintelligible sounds, smile, dart their eyes toward moving objects or sudden noises, and reflexively withdraw from noxious or painful stimuli.<sup>18</sup>

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<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 27-28.

<sup>14</sup> *Id.* at 28.

<sup>15</sup> *Id.* The difference between a coma and a persistent vegetative state is discussed *infra* note 17.

<sup>16</sup> *Id.*

<sup>17</sup> These are the main differences between comatose patients and PVS patients. Patients in comas are in more of a "sleeplike" state, with eyes closed, as a result of damage to the reticular activating system in the brain stem. Further, patients in comas do not have the cough and gag reflexes that exist in PVS patients. The cough, gag, and swallowing reflexes are actually of critical importance, as they clear the passages of the throat and lungs, thus preventing often fatal respiratory infections. Indeed, the retention of these reflexes is one of the main reasons PVS patients may survive for such long periods of time. *Id.*

<sup>18</sup> Council Report, *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, JAMA, January 19, 1990, at 426, 427.

It must be emphasized that, despite the appearance of being awake, PVS patients do not experience pain nor pleasure. Although these symptoms may deceive those outside the medical profession, it is well established in the medical community that such reactions from painful stimuli are peripheral only, and that PVS patients do not have the requisite consciousness to feel pain because of the loss of the cerebral cortex.<sup>19</sup> In fact, the defining factor for PVS patients is that they are totally unaware of themselves and their surroundings, and thus cannot experience any emotion or feeling whatsoever.<sup>20</sup>

Thus, PVS patients present those in the medical and legal profession with some interesting dilemmas. They are not "dead" according to society's traditional definition, because they have not experienced the requisite loss of the brain stem to qualify as "brain dead." Yet they are permanently unconscious, lack any awareness of themselves or their environment, and have no hope of recovery. It is with these medical realities that courts and legislatures have confronted the "right to die" issue.

### III. HISTORY AND OVERVIEW OF THE OHIO STATUTE

The right to die issue first presented itself in Ohio in a case concerning one Edna Marie Leach.<sup>21</sup> Leach, a seventy year old woman, suffered from amyotrophic lateral sclerosis, a disease that caused progressive deterioration of the nervous system which would eventually result in her death within three to five years.<sup>22</sup> She was admitted to Akron General Hospital on July 27, 1980, as her condition had severely worsened and she was having difficulty breathing.<sup>23</sup>

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<sup>19</sup> Cranford, *supra* note 1, at 31. Council Report, *supra* note 18, at 428. Indeed, it might very well be the deceiving characteristics of a PVS patient that have prompted many state legislatures to pass such restrictive laws concerning the termination of life support systems from PVS patients.

<sup>20</sup> Cranford, *supra* note 1, at 28; Council Report, *supra* note 18, at 427. In other words, "pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social functioning is possible." Jay Gold, *The Status of the Permanently Unconscious: "You Call that Living?"*, 42 MERCER L. REV. 1087, 1090 (1991) (citing PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 181-82 (1983)).

<sup>21</sup> *Leach v. Akron Gen. Medical Ctr.*, 426 N.E.2d 809 (Ohio Ct. App. 1980).

<sup>22</sup> *Id.* at 810.

<sup>23</sup> *Id.*

On July 29, while in the hospital, Leach suffered a coronary attack.<sup>24</sup> Her heartbeat was quickly restored, but she had to be placed on life support systems that included a respirator to enable her to breathe and a nasogastric tube for feeding. Thus, Leach not only suffered from a debilitating terminal illness, but was in a chronic vegetative state as a result of the cardiac arrest.<sup>25</sup>

Mr. Leach, after carefully considering his wife's predicament, requested that the life support systems be terminated. The attending physician, however, while acknowledging the hopelessness of her condition, stated that the life support systems could not be discontinued without a court order.<sup>26</sup> Mr. Leach thus petitioned the court to have the systems shut down.<sup>27</sup> At the trial, several witnesses close to Leach testified to numerous conversations with her in which she expressly stated she would not wish to be placed on life support systems.<sup>28</sup> The court was then forced to decide what right, if any, existed to allow Leach to be taken off life support systems.<sup>29</sup>

As this was a case of first impression in the State of Ohio, the court looked at case law in other jurisdictions for guidance: specifically, *In re Quinlan*,<sup>30</sup> and a New York case, *In re Eichner*.<sup>31</sup> Based on these two precedents the court held that an individual has a right to privacy that enables a person who is permanently unconscious and terminally ill to refuse life sustaining treatment,

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<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.* at 811.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 812.

<sup>30</sup> *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976). The case of Karen Quinlan is generally regarded as the grandfather of life support removal decisions. Karen Quinlan's life support systems included artificial nutrition and hydration as well as a respirator. Karen's father sought removal of the life support systems based on three grounds: 1) the constitutional right of freedom of religion; 2) the constitutional freedom from cruel and unusual punishment; and 3) the constitutional right to privacy. After rejecting the first two grounds, the Supreme Court of New Jersey allowed Karen's father to terminate the life support systems based on the constitutional right to privacy. *Id.* at 664.

<sup>31</sup> *In re Eichner*, 73 A.D.2d 431 (N.Y. 1980). In this case an eighty-three year old man was placed on life support systems after a cardiac arrest. After finding that he would not have wanted to be on life support systems had he been able to decide, the court allowed the life support systems to be terminated based on a constitutional right to privacy. *Id.* at 461. Although *Quinlan*, *Eichner*, and *Leach* all based their holdings on a constitutional right to privacy, the Supreme Court has stated that such interests must now be analyzed as a Fourteenth Amendment liberty interest instead. See *infra* notes 80-84 and accompanying text.

as long as it is established by clear and convincing evidence that this would have been the patient's desire.<sup>32</sup> This fundamental right to privacy could only be violated with a compelling state interest.<sup>33</sup>

The court then found that there was no sufficient state interest that could outweigh the individual's constitutional right to privacy.<sup>34</sup> Further, the court held that the burden of proof was satisfied by the testimony of Ms. Leach's friends and family.<sup>35</sup> As a result, the court ordered that the life support systems be terminated.<sup>36</sup> Thus, the *Leach* case seemed to establish a right to privacy in Ohio that would allow certain individuals to be taken off life support systems.

However, in 1989, the Ohio General Assembly enacted Ohio Revised Code sections 1337.11 through 1337.17.<sup>37</sup> The statute provides regulations allowing an individual to delegate to attorneys-in-fact the power to make health care decisions for the individual in case that person should become incapacitated and thus unable to make informed health care choices. The law, though, prevents an attorney-in-fact from withdrawing artificial nutrition or hydration from a principal unless the death of the principal was "imminent."<sup>38</sup> In other words, the statute forbids the removal of artificial nutrition and hydration when the principal would subsequently die as a result of malnutrition or dehydration.

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<sup>32</sup> *Leach v. Akron Gen. Medical Ctr.*, 426 N.W.2d 809, 816 (Ohio Ct. App. 1980).

<sup>33</sup> See generally *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

<sup>34</sup> *Leach*, 526 N.E.2d at 816.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> OHIO REV. CODE ANN. §§ 1337.11-.17 (Baldwin 1991).

<sup>38</sup> Section 1337.13 of the 1989 statute reads:

(E) An attorney in fact under a durable power of attorney for health care does not have authority to refuse or withdraw informed consent to the provision of nutrition and hydration to the principal, unless . . .

(2) In the opinion of the principal's attending physician and at least one other physician, either of the following situations exist:

(a) The death of the principal is imminent whether or not nutrition or hydration is provided to the principal, and the nonprovision of nutrition or hydration to the principal is not likely to result in the death of the principal by malnutrition or dehydration;

(b) If nutrition or hydration were provided to the principal, the nutrition or hydration either could not be assimilated or would shorten the life of the principal.

The impact of the statute can be seen in *Couture v. Couture*.<sup>39</sup> In *Couture*, twenty-nine year old Daniel Couture went into a coma, allegedly after taking certain medication.<sup>40</sup> Daniel was placed on life support systems that included a respirator and nutrition and hydration feeding tubes, but was eventually taken off the respirator and began breathing on his own.<sup>41</sup> However, Daniel still remained in a persistent vegetative state with no realistic hope for recovery.<sup>42</sup> Further, even with the continued administration of nutrition and hydration, Daniel would live only one to two months longer because of a continual buildup of fluid in his brain that would eventually cause the failure of his major bodily systems.<sup>43</sup>

Daniel's guardians and the Miami Valley Hospital contended that because Daniel was in a persistent vegetative state with little hope for recovery, and because sufficient evidence had been presented showing Daniel would have objected to the life support systems, the guardians and the hospital had the legal right to discontinue life support treatment.<sup>44</sup> The court disagreed.<sup>45</sup> Citing the Ohio Revised Code, section 1337.13, the court found that because attorneys-in-fact are not permitted to withdraw nutrition and hydration unless the death of the principal is imminent, then a guardian's power must also be limited by the statute.<sup>46</sup> Indeed, the court logically concluded that because a guardian's decision to discontinue life support relies on casual oral remarks, as opposed to an attorney-in-fact whose power comes from an express writing, then a guardian's right to discontinue nutrition and hydration is even less compelling than an attorney-in-fact.<sup>47</sup> Thus, because the court concluded that Daniel's guardian had no more power than an attorney-in-fact under the statute, and because Daniel's death could not be considered imminent, Daniel's nutrition and hydration could not be removed.<sup>48</sup> The *Couture* decision thus severely limited the ability to remove individuals from artificial nutrition and hydration.

However, on October 10, 1991, just slightly two years after the *Couture* decision, Senate Bill One went into effect, again changing the state of the law

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<sup>39</sup> *Couture v. Couture*, 549 N.E.2d 571 (Ohio Ct. App. 1989).

<sup>40</sup> *Id.* at 572.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.* at 573.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.* at 577.

<sup>46</sup> *Id.* at 574-76.

<sup>47</sup> *Id.* at 576.

<sup>48</sup> *Id.* at 577.

in Ohio concerning the removal of life support systems from incapacitated patients.<sup>49</sup> Ohio's new living will statute provides individuals with two ways of determining how decisions concerning life support systems will be made if they should be unable to make those decisions for themselves.<sup>50</sup>

The first possibility is that an individual may establish a durable power of attorney for health care, or a DPAHC.<sup>51</sup> That is, an individual may execute a document that gives another person the power to make medical decisions for that individual if the individual becomes unable to make such decisions.<sup>52</sup>

The second way the Ohio statute allows an individual to indicate his or her desires concerning life-sustaining treatment is through a living will.<sup>53</sup> A living will is a legal document in which a person indicates his or her desires regarding the administration of life-sustaining treatment should they become either terminally ill, permanently unconscious, or both.<sup>54</sup> Prior to the enactment of the new statute, living wills were not recognized in the State of Ohio.<sup>55</sup>

The regulations governing living wills and DPAHC are lengthy and detailed, but in most respects, the Ohio statute is similar to other state statutes authorizing advance directives.<sup>56</sup> The most controversial part of Ohio's living will statute, however, is the provision governing incapacitated patients that

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<sup>49</sup> 1991 Ohio Laws File 36 (S.B. 1).

<sup>50</sup> OHIO REV. CODE ANN. §§ 1337.11-.17, 2133.01-.15 (Baldwin 1991).

<sup>51</sup> *Id.* § 1337.12.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.* § 2133.02(A)(1), (2).

<sup>54</sup> *Id.* The Ohio statute defines a permanently unconscious state as "a state of permanent unconsciousness in a principal that . . . is characterized by both of the following: (1) The principal is irreversibly unaware of himself and his environment. (2) There is a total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering." OHIO REV. CODE ANN. § 1337.11(T) (Baldwin 1991).

Terminal condition is defined as "an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical standards . . . both of the following apply: (1) There can be no recovery. (2) Death is likely to occur within a relatively short period of time if life-sustaining treatment is not administered." OHIO REV. CODE ANN. § 1337.11(Y) (Baldwin 1991).

<sup>55</sup> The 1989 laws did not recognize living wills, thus their validity could have been used only to express the individual's desire concerning life support. However, knowledge of the individual's desire was irrelevant under the 1989 statute. *See supra* notes 44-48 and accompanying text.

<sup>56</sup> For a detailed analysis of the mechanics surrounding the implementation and results of making an advance directive under the Ohio statute, see William M. Todd, *Directing Health-Care Choices*, OHIO LAWYER, September/October 1991, at 10.



have not left an advance directive.<sup>57</sup> In the case of terminally ill patients, the Ohio statute allows the next of kin to terminate the life support systems as long as the decision is made in good faith and is consistent with what the terminally ill patient would have desired.<sup>58</sup>

However, the Ohio statute treats permanently unconscious patients who are also terminally ill differently than those who are not. The statute mandates that permanently unconscious but not terminally ill patients who do not have an advance directive cannot have life support systems removed by the next of kin for twelve months.<sup>59</sup> Further, the removal of artificial nutrition and hydration, as opposed to the removal of other forms of life support such as respirators, may only be removed with approval from the probate court, which takes an additional one to two months.<sup>60</sup>

The probate court can approve the removal of artificial nutrition and hydration from a permanently unconscious patient who has not left an advance directive only if the following conditions are established by clear and convincing evidence: 1) The patient is no longer able to make such decisions and is not likely to regain such capacity; 2) the consent process complied with the requirements of the law; 3) the withdrawal of artificial nutrients is within the patient's previously expressed wishes; 4) the patient is in a permanently unconscious state and has been in such state for at least the preceding twelve months.<sup>61</sup> These provisions, in effect, prevent a permanently unconscious patient without an advance directive from having life support systems removed for twelve to fourteen months.

The Ohio statute attempts to solve the problems surrounding the difficult decisions of removing life support systems by providing an individual with the opportunity to implement an advance directive. The fact of the matter is, however, that most people will never put an advance directive into effect.<sup>62</sup> As a result, most permanently unconscious patients in Ohio will remain on life

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<sup>57</sup> *Id.* at 10-13.

<sup>58</sup> OHIO REV. CODE ANN. § 2133.08 (Baldwin 1991).

<sup>59</sup> *Id.* § 2133.09.

<sup>60</sup> *Id.* § 2133.09(A)(6).

<sup>61</sup> *Id.* § 2133.09(C)(2).

<sup>62</sup> Studies seem to vary, but at least one shows that only 9% of the population has executed advance directives. Gasner, *supra* note 4, at 8 (citing Emmanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 JAMA 3288 (1989)); see also *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 292 n.1 (1990) (citing *American Medical Association Surveys of Physician and Public Opinion on Health Care Issues* 29-30 (1988) (stating 15% of those surveyed had executed a living will)).

support systems for at least one year, even if it is contrary to their wishes as expressed at other times and in other ways.

Whether or not the Ohio statute infringes on an individual's constitutional rights is unclear. The Supreme Court has dealt with the right to die issue only once, in the landmark case *Cruzan v. Missouri Department of Health*.<sup>63</sup> The Court's holding, however, was extremely narrow and provided little guidance to the states for defining acceptable boundaries in limiting the removal of life-sustaining treatment.<sup>64</sup> Regardless, to determine the constitutional validity of the Ohio provision, the statute must be analyzed in light of *Cruzan*, as it is the only case in which the Court has spoken on this issue.

#### IV. THE CRUZAN DECISION

On January 11, 1983, twenty-five year old Nancy Cruzan lost control of her car while driving late one evening in Jasper County, Missouri.<sup>65</sup> The car overturned, and when paramedics arrived, they discovered Cruzan lying face down in a ditch without respiratory and cardiac functions.<sup>66</sup> Although the paramedics restored her heartbeat and breathing, Nancy Cruzan remained in a permanent vegetative state, without the cognitive or reflexive ability to swallow food.<sup>67</sup> Further, the paramedics estimated that her brain was deprived of oxygen for twelve to fourteen minutes, resulting in irreversible brain damage, and rendering her a spastic quadriplegic.<sup>68</sup>

When it became evident that Nancy Cruzan would never regain consciousness, her parents requested that the life support systems be terminated.<sup>69</sup> The hospital, however, refused to terminate the systems without a court order.<sup>70</sup> The parents sought a court order but were denied because the

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<sup>63</sup> 497 U.S. 261 (1990).

<sup>64</sup> The Court stated that when "deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'" *Id.* at 277 (quoting *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897)).

<sup>65</sup> *Id.* at 266.

<sup>66</sup> *Id.* Footnote one of the opinion contains a complete description of the state supreme court's findings concerning Nancy Cruzan's condition, including the fact that she was "oblivious to her environment except for reflexive responses to sound and perhaps painful stimuli."

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.* at 267.

<sup>70</sup> *Id.* at 268.

State of Missouri would not allow the termination of artificial nutrition and hydration unless it could be shown by clear and convincing evidence that the incapacitated patient would have wished to be taken off life support systems. The Missouri Supreme Court then found that the parents had not sustained their burden of proof and denied the parents' request.<sup>71</sup>

The parents of Nancy Cruzan appealed to the Supreme Court of the United States claiming that the "clear and convincing" evidence standard was too high a burden of proof and was thus unconstitutional based on the Fourteenth Amendment Due Process Clause.<sup>72</sup> The Supreme Court, by a five to four vote, rejected the parents' claim and upheld Missouri's clear and convincing evidence standard.<sup>73</sup>

Chief Justice Rehnquist's majority opinion, however, does seem to indicate that there are limits on a state's power to force artificial nutrition and hydration on a permanently unconscious patient. The Court noted at the outset that it is generally accepted that a competent individual has the right to refuse medical treatment.<sup>74</sup> The Court then had to decide, however, whether the right of a competent person to refuse medical treatment included the right to refuse lifesaving nutrition and hydration, in light of the "dramatic consequences involved in the refusal of such treatment."<sup>75</sup>

Whether or not the Court actually recognized such a right is still a matter of some debate.<sup>76</sup> The Court stated that for the purposes of the present case,

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<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 269. Although the decision was five to four, the makeup of the Supreme Court has changed since the decision. Two of the dissenting justices, Justice Brennan and Justice Marshall, have been replaced by Justices Souter and Thomas, respectively. It is very possible that the two new justices will be more protective of the state legislatures' power to regulate in this area as well as others.

<sup>74</sup> *Id.* The Court noted that the doctrine of informed consent is well established in American tort law. *See* W. PAGE KEETON ET AL., PROSSER & KEETON ON LAW OF TORTS § 9, at 189-92 (5th ed. 1984). The Court, citing previous cases, then noted that the right to refuse medical treatment also has constitutional dimensions. *See* *Washington v. Harper*, 494 U.S. 210 (1990) (finding that liberty interests were implicated through forced injections into nonconsenting individuals); *Vitek v. Jones*, 445 U.S. 480 (1980) (mandatory behavior modification treatment implicated liberty interests).

<sup>75</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 (1990).

<sup>76</sup> *See, e.g.,* John Nicholas Suhr, Jr., *Cruzan v. Director, Missouri Department of Health: A Clear and Convincing Call for Comprehensive Legislation to Protect Incompetent Patients' Rights*, 40 AM. U. L. REV. 1477, 1540 (1991) ("The majority found that a competent person has a constitutionally protected liberty interest in refusing life-sustaining nutrition and hydration."). *But cf.* William Leschensky, *Constitutional Protection of the*

they would "assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition," thus causing some disagreement as to whether the Court has actually established such a right.<sup>77</sup> The opinion, however, should probably be read as recognizing the right to refuse such treatment because the Court later reiterated the existence of this right when it stated that "the due process clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment."<sup>78</sup> Justice O'Connor's concurrence stated that she agreed with the majority opinion that a liberty interest exists that allows an individual to refuse artificial nutrition and hydration.<sup>79</sup> Thus, the *Cruzan* case seems to establish that a competent person has the right to refuse artificially delivered nutrition and hydration.

Assuming that such a right exists, it should be noted that the right stems not from a general constitutional right to privacy, however, but from a Fourteenth Amendment liberty interest.<sup>80</sup> This distinction is crucial because had the right been established as a fundamental right to privacy, only a compelling state interest would have allowed the states to infringe on this right.<sup>81</sup> Because the Court considered the right as a Fourteenth Amendment liberty interest instead, the individual has somewhat less protection.<sup>82</sup> Under a Fourteenth Amendment analysis, the Court must balance the individual's liberty interest against the relevant state interests to determine whether there has been a constitutional infringement.<sup>83</sup> Only if the individual interests outweigh the state interests will a constitutional violation exist.<sup>84</sup>

Further, it is extremely important that although the Court recognized that a competent individual has the right to refuse life-sustaining treatment, the Court made explicit that an *incompetent* person's right to refuse life-sustaining treatment is different because the right must be exercised through a surrogate.<sup>85</sup>

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*Refusal-of-Treatment:* *Cruzan v. Director, Missouri Department of Health*, 14 HARV. J. L. & PUB. POL'Y 248, 249 (1991) ("The *Cruzan* majority did not decide, however, whether this liberty interest extends to the refusal of lifesaving hydration and nutrition.").

<sup>77</sup> *Cruzan*, 497 U.S. at 279.

<sup>78</sup> *Id.* at 281.

<sup>79</sup> *Id.* at 287.

<sup>80</sup> *Id.* at 279 n.7.

<sup>81</sup> See Jennifer E. Bennett Overton, *Unanswered Implications—The Clouded Rights of the Incompetent Patient Under Cruzan v. Director, Missouri Department of Health*, 69 N.C. L. REV. 1293, 1307 (1991).

<sup>82</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 n.7 (1990).

<sup>83</sup> *Id.* at 278.

<sup>84</sup> *Id.*

<sup>85</sup> *Id.* at 280.

It could have been argued that the Equal Protection Clause mandated that an incompetent person's right to refuse treatment must be honored by the state in the same manner as a competent person's because the state must treat them equally. The Court's recognition of the differences between competent and incompetent patients, however, now apparently precludes the families of the patient from making an Equal Protection Clause argument.<sup>86</sup>

Also, the difference between a competent and incompetent person's ability to exercise their liberty interest proved crucial to the Court's decision.<sup>87</sup> When balancing the rights of the individual and the interests of the state, the Court recognized that the state has an interest in "the protection and preservation of human life."<sup>88</sup> However, this general state interest in human life was not the basis on which the Court upheld Missouri's clear and convincing evidence standard.<sup>89</sup> Instead, the Court found that, in the present case, the state "has more particular interests at stake."<sup>90</sup> For example, the states may guard against potential abuses of surrogates who would terminate life support systems in their own self interest, regardless of the wishes of the patient.<sup>91</sup> Further, the states may also impose a heightened evidentiary standard to ensure that the factfinding process remains accurate, as it is likely that the adversarial process, and thus the accuracy of the determinations, will be diminished.<sup>92</sup> It was these more particular state interests that made the Court's decision relatively easy in upholding Missouri's clear and convincing evidence standard.

The *Cruzan* decision thus answered several important questions surrounding the right to die issue. The case apparently established a Fourteenth Amendment liberty interest in refusing artificial nutrition and hydration. However, an incompetent person's right to refuse such treatment is not necessarily equal to that of a competent person's because the wishes of an incompetent patient who has not left an advance directive are not easily known. The patient's interest must then be balanced against the state interests. Included

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<sup>86</sup> The state trial court partially relied on the Equal Protection Clause in deciding that Nancy Cruzan had a right to have the nutrition and hydration terminated. *Cruzan v. Harman*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). This argument, though, would now seem to be moot. *See Cruzan*, 497 U.S. at 287 n.12 (rejecting petitioners' Equal Protection Clause claim on grounds that competent and incompetent persons are not similarly situated).

<sup>87</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279-80 (1990).

<sup>88</sup> *Id.* at 280.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.* at 281.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

among state interests are the protection and preservation of human life, and most importantly to the *Cruzan* holding, an interest in accurately determining the incompetent person's wishes. It is against these findings that the Ohio statute must now be compared.

#### V. ANALYSIS OF THE OHIO STATUTE IN LIGHT OF *CRUZAN*

The Ohio statute presents a more difficult constitutional issue than the *Cruzan* case. The Ohio living will statute mandates that a person without an advance directive in a permanently unconscious state being sustained through artificial nutrition and hydration, such as Nancy Cruzan, could not have the artificial nutrition and hydration removed for over one year.<sup>93</sup> Even with proof that satisfies the clear and convincing evidence standard, the guardians of an individual such as Nancy Cruzan would have to wait over a year before the life sustaining treatment could be removed. This rigorous standard may deny permanently unconscious patients their Fourteenth Amendment rights under the decision.

In *Cruzan*, the Supreme Court recognized that individuals have a Fourteenth Amendment liberty interest in refusing unwanted medical treatment.<sup>94</sup> The Court, however, upheld Missouri's clear and convincing evidence standard on the ground that the state had a legitimate interest in preserving human life that had to be balanced against the individual's interest.<sup>95</sup> Most importantly, however, the Supreme Court recognized that the clear and convincing evidence standard should be upheld because the state had a legitimate interest in making certain that the surrogate decisionmakers were actually performing the will of the incompetent patient.<sup>96</sup> In other words, the heightened level of scrutiny served a legitimate state interest in assuring that the surrogate decisionmakers were acting out the actual wishes of the patient and not in their own self interest, whatever it may be.

However, the Ohio statute cannot be justified on any such grounds. The year long wait will not serve to clarify or protect the patient's actual wishes. After all the relevant evidence is weighed, the patient's guardians will either be able to prove the incompetent person's desire to be removed from life support systems, or they will not. If they fail to offer enough evidence, the state may refuse to withdraw life support treatment. If, however, clear and convincing

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<sup>93</sup> See *supra* notes 58–59 and accompanying text.

<sup>94</sup> See *supra* notes 73–80 and accompanying text.

<sup>95</sup> See *supra* note 87 and accompanying text.

<sup>96</sup> See *supra* notes 88–91 and accompanying text.

evidence is offered that proves the patient would not wish to be on life support systems, any further postponement of the patient's wishes does not become a protection for the patient. It is merely an unnecessary delay in carrying out the individual's desires.

Thus, although Missouri's heightened evidentiary standard may be justified on the grounds that it helps assure the patient's true desires are being carried out, Ohio's statute serves no such purpose. The State of Ohio is not attempting to assure that the patient's actual wishes are being implemented. Indeed, the Ohio statute is doing exactly the opposite. It forces an incompetent patient without an advance directive to stay on life-sustaining treatment for one year regardless of the amount of evidence the guardians may offer proving that the patient's wishes are to the contrary. As a result, the year long provision cannot be upheld on the same reasoning that the Missouri statute was upheld, because Ohio's provision is not protecting the same state interest that was recognized in the *Cruzan* case.

Thus, because Ohio's statute is not protecting the legitimate state interest recognized in *Cruzan*, it must be protecting some other legitimate state interest in order to be upheld.<sup>97</sup> If the provision is not protecting another legitimate state interest, than the provision cannot be upheld because there will be no state interest of greater magnitude than the individual's liberty interest.

Aside from the "particular" state interests found in the *Cruzan* case, four state interests have been generally recognized for the purposes of analyzing right to die cases: The integrity of the medical profession; the protection of third parties; the prevention of suicide; and the preservation of life.<sup>98</sup> The Ohio statute must now be analyzed with respect to these interests.

#### *A. The Integrity of the Medical Profession*

A physician has a duty to provide a patient with any care necessary to the maintenance of the patient's health.<sup>99</sup> Although any specific treatment given by a physician must be knowingly and voluntarily consented to, such consent may be implied in emergency situations when the patient is incapacitated.<sup>100</sup> Thus, it may be argued that doctors are under an ethical duty to presume that all

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<sup>97</sup> See *supra* notes 81-83 and accompanying text.

<sup>98</sup> See Ben A. Rich, *The Assault on Privacy in Healthcare Decisionmaking*, 68 DENV. U.L. REV. 1, 11-16 (1991); Gasner, *supra* note 4, at 22 (noting that these state interests have been "repeatedly recited").

<sup>99</sup> James Bopp, Jr. & Daniel Avila, *Trends in the Law: From Death to Life*, 27 IDAHO L. REV. 1, 5 (1990).

<sup>100</sup> *Id.*

incapacitated patients would wish to have their life prolonged by life support systems. This duty would then require the doctors to maintain a permanently unconscious patient on life support systems until the patient died, or the treatment became burdensome or excessive.<sup>101</sup>

Such a view, however, rests on the mistaken presumption that doctors have a duty to apply all aspects of medical technology in every situation. Increasingly, physicians and nonphysicians alike have begun to realize that in some instances medical care is intrusive and degrading.<sup>102</sup> Also, it should be emphasized that the physician/patient relationship is primarily a contractual one, with the physician obligated to provide only that treatment which the patient desires.<sup>103</sup> Thus, when there is clear evidence indicating that the patient would not wish such life sustaining treatment, it is obvious that the physician should not be required to treat the patient.

Finally, it should be dispositive that the major medical organizations do not object to the withdrawal of artificial nutrition and hydration if the patient's wishes are known.<sup>104</sup> It would be anomalous to assert that the state, in the

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<sup>101</sup> *Id.* at 5. It should be noted that the physician is under no duty to provide extraordinary care, that is, care in which the burdens on the patient greatly exceed the benefits of treatment. *Id.* Some courts have explicitly held that life sustaining treatment is burdensome, thus greatly reducing any valid arguments that such treatment is mandated by medical ethics. *See, e.g., In re Drabick*, 245 Cal. Rptr. 840, 845, *cert. denied*, 488 U.S. 958 (1988); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 637 (Mass. 1986).

<sup>102</sup> *See Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1644 (1991) (stating that, depending upon the situation, 75–99% of the physicians asked thought that withdrawal of life-sustaining treatment is proper); *see also* Marcia Coyle, *How Americans View the High Court*, NAT'L L.J., February 26, 1990 at 36 col. 1 (88% of the population at large think that family should decide issues regarding life-sustaining treatment if the patient is comatose with no hope of recovery).

<sup>103</sup> Rich, *supra* note 98, at 4.

<sup>104</sup> The American Medical Association states:

Even if death is not imminent but a patient is beyond doubt permanently unconscious, and there are adequate safeguards to confirm the accuracy of the diagnosis, it is not unethical to discontinue all means of life-prolonging medical treatment. . . . If the patient is incompetent to act on his own behalf and did not previously indicate his preferences, the family or other surrogate decisionmaker, in concert with the physician, must act in the best interest of the patient. . . .

American Medical Association Council, AMA Ethical Opinion 2.18, *Withholding or Withdrawing Life-Prolonging Medical Treatment*, in CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1986). The American Academy of Neurology states:



name of medical integrity, could force doctors to give treatments that they do not wish to give, nor the patients receive. As a result, it is perfectly in line with medical ethics to refrain from giving artificial nutrition and hydration when clear and convincing evidence is available that the patient would not wish such treatment. Thus, the Ohio statute should not be able to be upheld based on the state's interest in protecting the ethics of the medical profession.

### *B. Protection of Third Parties*

The interest of the state in protecting third parties is primarily concerned with either the unborn child of the unconscious patient, or the patient's minor children.<sup>105</sup> As for the interests of the unborn child, the Ohio statute has specific provisions dealing with pregnant women who are either permanently unconscious, terminally ill, or both.<sup>106</sup> Those provisions raise different issues that are sufficiently complex that they merit much more attention than can be given here. Thus, for the purposes of this paper, it will be assumed that the patient is not pregnant.

As for the interests of the minor child, there is some difficulty in the contention that a parent's constitutional right should be less protected than the rights of others.<sup>107</sup> If a constitutional right exists in refusing artificial nutrition and hydration, then that right should probably be applied equally to parents and nonparents alike.<sup>108</sup> Further, it is difficult to imagine what interest a minor child has in keeping a permanently unconscious parent alive. The incapacitated parent can offer the child neither affection nor attention, and there is no economic benefit to the child in keeping the parent on life support systems. Thus, the state has no credible interest in protecting minor children that would justify keeping an individual on life support systems contrary to his or her wishes.

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[T]he decision to discontinue [the artificial provision of fluid and nutrition] should be made in the same manner as other medical decisions, i.e., based on a careful evaluation of the patient's diagnosis and prognosis, the prospective benefits and burdens of the treatment, and the stated preferences of the patient and family.

American Academy of Neurology, *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 NEUROLOGY 123, 125 (1989).

<sup>105</sup> Rich, *supra* note 98, at 14-15.

<sup>106</sup> OHIO REV. CODE ANN. § 1337.13(B) (Baldwin 1991).

<sup>107</sup> Rich, *supra* note 98, at 15.

<sup>108</sup> *Id.*

### C. Prevention of Suicide

The Court in *Cruzan* explicitly recognized the state interests of preventing suicide and preserving life.<sup>109</sup> Although the majority opinion did not characterize the removal of artificial nutrition and hydration as an act of suicide the state could prevent, such an argument could still be made because the Court reached its holding on other grounds without ever discussing the issue.

However, at least one member of the Court, Justice Scalia, would have upheld the Missouri law based on the state's right to prevent suicide.<sup>110</sup> It is Justice Scalia's belief that it is the job of the states, not the Court, to decide at what point the failure to take action to preserve one's life is suicidal.<sup>111</sup> In other words, because there is no traditional right to commit suicide, the Constitution in no way inhibits the state from defining suicide as the refusal to take artificial nutrition and hydration, and then forcing the individual to be sustained on such treatment.<sup>112</sup> Thus, an argument can be made that the Ohio statute is constitutional, based on the state's interest in preventing suicide.

Given the traditional interpretation and definition of suicide, though, most commentators and judges have come to the conclusion that the termination of life support systems is not a suicidal act.<sup>113</sup> This is because suicide is generally thought of as an affirmative act on the part of the individual to end one's life.<sup>114</sup>

Justice Scalia points out, though, that the distinction does not lie between action and inaction, but between what constitutes ordinary measures or heroic measures to preserve one's life.<sup>115</sup> For example, there is no distinction between throwing oneself into the sea to be drowned, or sitting on the beach waiting for the tide to take one's life.<sup>116</sup> Thus, according to Justice Scalia, it is up to the legislatures, not the courts, to determine what are the ordinary measures one must take to preserve her life.<sup>117</sup>

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<sup>109</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 280 (1990).

<sup>110</sup> *Id.* at 295.

<sup>111</sup> *Id.* at 300.

<sup>112</sup> *Id.* at 294-96.

<sup>113</sup> See Rich, *supra* note 98, at 9; Roberts, *supra* note 102, at 1668 (calling the state interest in suicide "relatively insignificant").

<sup>114</sup> *Guardianship of Doe*, 583 N.E.2d 1263, 1270 (Mass.), *cert. denied*, 112 S. Ct. 1512 (1992).

<sup>115</sup> *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296 (1990).

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

Justice Scalia's argument misses the point. As Justice Scalia himself states, suicide is a "conscious" decision to end one's life.<sup>118</sup> It is this very element of consciousness which prevents the removal of life supports from PVS patients from being a suicidal act. In other words, suicide is presumed to be a conscious decision, made by a conscious individual, to end one's conscious life. People in a permanently vegetative state, however, are not making a conscious decision to end their conscious life. They are instead deciding that their conscious lives are so precious to them, that they do not want their bodies artificially sustained if they should ever become unconscious by natural causes beyond their control. Thus, the termination of life support systems can be readily distinguished from other acts that might constitute suicide.

Regardless of the above distinctions, when the Ohio living will statute is read as a whole, it becomes obvious that the provision cannot be justified on the state interest in preventing suicide. Although Ohio, like all the states, does have an interest in preventing people from taking their own life through suicide, this interest does not manifest itself in this case. The State of Ohio has already made clear its decision that the removal of artificial nutrition and hydration from a permanently unconscious patient is not a suicidal act.<sup>119</sup> It has done so in the living will statute that expressly allows for such removal of the artificial nutrients with a proper advance directive.

Thus, because Ohio has already determined that it is not suicide to remove artificial nutrition and hydration from patients with advance directives, the state should not be able to invoke the state interest in preventing suicide for those patients who have failed to make an advance directive. It cannot seriously be maintained that one who chooses to forego artificial nutrition and hydration through an advance directive has not attempted suicide, while one who makes the same decision but fails to document it in an advance directive, has attempted a suicide the state can prevent or delay.

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<sup>118</sup> *Id.*

<sup>119</sup> The Ohio statute expressly provides that "[t]he death of a qualified patient or other patient resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this chapter does not constitute suicide, aggravated murder, murder, or any other homicide offense for any purpose." OHIO REV. CODE ANN. § 2133.12(A) (Baldwin 1991).

This section would seem, on its face, to apply to all patients, including patients that have not executed an advance directive but instead have been permanently unconscious for twelve months. The state would be hard pressed to argue that individuals who terminate life support immediately through an advance directive have not committed suicide, while individuals who do so ten months later without advance directives are deemed to have committed suicide.

In short, because the state has already characterized the decision to forego artificial nutrition and hydration as a valid medical decision, it cannot claim that the same decision, proven by clear and convincing evidence but not documented in a living will, is a suicide attempt the state has an interest in preventing. Thus, the state cannot maintain an interest paramount to that of the individual based on the state's interest in preventing suicide.

#### *D. Preservation of Life*

The last state interest, and one expressly mentioned in the *Cruzan* decision, is the state's interest in preserving life.<sup>120</sup> This has been generally recognized as the most powerful state interest, and was the primary state interest relied on in the Supreme Court's opinion. In *Cruzan*, the Court stated that a state may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.<sup>121</sup> What is troubling about the Court's language is that it seems to indicate that the state may sustain an individual on artificial nutrition and hydration indefinitely, without considering how long the individual has been unconscious, the prospects for recovery, or what is best for the patient.

This language, however, should not be read as giving the states such broad powers. Instead, the Court is probably simply preventing itself from going down the "slippery slope" of deciding whether some lives are more important than others. For example, the Court wanted to make clear that a paralyzed person's life is not worth any less simply because that person might not have the quality of life of a person not paralyzed. The language of the state court holding regarding the interest in preserving life further illustrates this point. The Supreme Court of Missouri stated:

It is tempting to equate the state's interest in the preservation of life with some measure of quality of life. . . . But the state's interest is not in quality of life. . . . Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified.<sup>122</sup>

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<sup>120</sup> *Cruzan*, 497 U.S. at 280.

<sup>121</sup> *Id.* at 282.

<sup>122</sup> *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

The court's (and Supreme Court's) announcement is absolutely correct in the sense that no one would assert that the state must find a handicapped person's life less valuable than a nonhandicapped person's. People with disabilities, though, may not only be productive members of society, but most importantly are also still experiencing life. However, the permanently unconscious do not have, and never again will have, any awareness of their environment or surroundings that make up what most of us consider "life."

In other words, the fear that society will begin valuing some people's lives more than others, although a valid concern, does not manifest itself in the case of the permanently unconscious. This is because a bright line test may be drawn between the permanently unconscious, who have no cognizant awareness, and those who do have consciousness at any level. Thus, although the Court held that the state may assert an unqualified interest in life, it was probably simply preventing itself from going down the "slippery slope" of valuing human life based on age, intelligence, handicap, and other similar criteria. This protection, however, should not be applicable to the permanently unconscious, as they can be readily distinguished from conscious people who may suffer from handicaps or any other debilitating condition.<sup>123</sup>

The Court's language might also indicate, however, that the state may assert an unqualified interest in preserving a permanently unconscious patient, regardless of the patient's quality of life, or lack thereof, while on life-sustaining treatment. Regardless, even if the states could claim an interest in sustaining patients just for the sake of prolonging an unconscious life, it is difficult to fathom how this state interest could outweigh the individual's liberty interest when balanced against it. A permanently unconscious individual offers no benefit to society as a whole.<sup>124</sup> They cannot be productive members of

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<sup>123</sup>As Justice Brennan pointed out, the majority's holding could lead down an equally dangerous "slippery slope." For example, it is not obvious from the *Cruzan* decision why the state could not remove a kidney from Nancy and give it to an ailing third party, take skin grafts or bone grafts from her, or use her body for experimentation. *Cruzan*, 497 U.S. at 313 n.13 (Brennan, J., dissenting). Such actions on the part of the state would surely be prohibited by the Constitution. *Id.*

<sup>124</sup>In fact, PVS patients represent a tremendous burden on society. The cost of care for a PVS patient can range from \$2,000 to \$10,000 per month. Considered in light of the number of PVS patients that must be taken care of annually, the health cost for these patients may range from \$120 million to \$1.2 billion per year. Cranford, *supra* note 1, at 31-32. This is not in any way to insinuate that lives which "cost" more to sustain should be determined less valuable than other lives. Instead, the cost of these patients merely lessens the credibility of a state interest in the life of a PVS patient that outweighs the patient's own interest in refusing unwanted medical treatment.

society, nor enjoy any of the pleasures or comforts that society has to offer them.<sup>125</sup> Thus, the state interest in preserving a PVS life should not outweigh an individual liberty interest in refusing unwanted medical treatment.

What is more compelling, perhaps, is the state interest in preserving a PVS life in the hopes that the patient will recover. This interest is, in fact, exactly what the Ohio legislature appears to have been protecting when it enacted the year-wait provision.<sup>126</sup> The legislators obviously felt that individuals without advance directives should be given one year of life-sustaining treatment in the hope that they come out of their chronic vegetative state. Thus, the state may contend that the provision protects a legitimate state interest in preserving life in the hope of recovery.

Despite the fact that, on occasion, miraculous recoveries have happened,<sup>127</sup> the state's interest in preserving life should not be paramount to the individual's liberty interest. The truth of the matter is that the chances of recovery after having fallen into a persistent vegetative state are less than

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<sup>125</sup> The fact that PVS patients cannot experience or appreciate anything that society has to offer is probably a more compelling reason to assert that the state's interest in preserving life does not outweigh the individual's liberty interest. Indeed, it would be unsettling to assert that the state has a greater interest in preserving the more "productive" lives, as this would lead down the "slippery slope" discussed earlier in which handicapped persons' lives would be worth less than people without handicaps. But in the situation of a PVS patient, in which not only is the patient completely incapacitated, but also *completely unable to enjoy or experience "society" or his environment on any level*, it is less troubling to assert that the state interest is diminished when compared to the individual's liberty interest.

<sup>126</sup> The year wait can really not be justified on any other ground. Further, state Senator Betty Montgomery, the main sponsor of the bill, indicated that this was the primary reason for the provision at a discussion on the bill.

<sup>127</sup> Perhaps the most well known example of this phenomenon is one Carrie Coons. In October of 1988, the eighty-six year old woman suffered a massive stroke that eventually caused her to lapse into unconsciousness. She was able to breathe on her own, but was placed on artificial nutrition and hydration to sustain her. A few days after the trial court ruled that there was sufficient evidence to remove Ms. Coons from the systems, she awoke.

She was able to ingest small amounts of food on her own, and was able to speak somewhat, although communication with her was difficult and sporadic. As expected, the trial court quickly revoked its order. The reasons for Ms. Coons' recovery are unknown, although it was documented that the nursing staff aggressively stimulated her and tried to feed her by mouth. Ms. Coons' condition remains unchanged. See Stephan Haimowitz & Robin Goldman, *A Patient Returns from "Death with Dignity": Error, Uncertainty and the Right to Die*, N.Y. ST. B.J., OCT. 1990, at 58, 59.

infinitesimal.<sup>128</sup> Thus, given the pain and hardship imposed on those close to the patient along with lack of a feasible chance of recovering, the balance should tip in favor of individual choice. Families and friends should not have to sit idly by while the chronically vegetative patient is force fed artificial nutrients. The decision to terminate the life support systems should be made by the family, as long as they can provide clear and convincing evidence that they are carrying out the patient's desires.<sup>129</sup> Thus, even a state interest in preserving a PVS patient in the hopes of recovery should not be deemed greater than the individual's liberty interest.

## VI. THE CRITICAL LOOK

Because the right to die issue first appeared in the judicial sphere, the courts have struggled considerably with the problem of finding suitable doctrines with which to deal with nondeclarants. The two tests that have been most utilized by the courts are: (1) the substituted judgment doctrine; and (2) the best interests test. The substituted judgment doctrine requires the judge to place herself in the position of the incompetent patient and determine whether the patient would wish to continue the life sustaining procedures.<sup>130</sup> The best interest test, on the other hand, does not look into the desires of the patient, but instead forces the judge to determine whether it is in the patient's best interest to maintain treatment.<sup>131</sup>

Despite the frequency with which these tests are used, both have recently been criticized as being intellectually dishonest and judicially unsound. Critics of the substituted judgment doctrine point out that it is impossible to know what the nondeclarant would have preferred, and any decision reached is

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<sup>128</sup> Over 10,000 patients, including Nancy Cruzan, have fallen into a persistent vegetative state in the last twenty years from loss of oxygen to the brain. Of those 10,000 patients, medical literature has documented only three partial recoveries. See Brief of the American Medical Association as Amicus Curiae at 11-12, *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990) (No. 88-1503).

<sup>129</sup> See generally Cindy Rushton & Elizabeth Hogue, *The Role of Families as Surrogate Decisionmakers after Cruzan v. Director, Missouri Department of Health*, 7 J. CONTEMP. HEALTH L. & POL'Y 219 (1991) (positing that the decision to remove life support systems should belong exclusively to the family, subject to appeal to the courts only by the attending physicians if they believe the family is not acting in the best interests of the patient).

<sup>130</sup> See, e.g., *In re Estate of Longeway*, 549 N.E.2d 292, 299-300 (Ill. 1989); *Guardianship of Doe*, 583 N.E.2d 1236, 1267-69 (Mass.), cert. denied, 112 S. Ct. 1512 (1992); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633-35 (Mass. 1986).

<sup>131</sup> See, e.g., *In re Conroy*, 486 A.2d 1209, 1231-33 (N.J. 1985).

tainted with the biases of the judge, the family, and the doctors.<sup>132</sup> The best interest test, on the other hand, is not really a best interest test at all, because permanently unconscious patients can neither feel, think, nor experience, and thus do not have a "best interest."<sup>133</sup>

As a result of the growing dissatisfaction with the judicial standards, the courts and commentators have looked to the legislature for a solution to this dilemma. The Ohio Legislature answered the call, but failed to come up with a solution that adequately dealt with the problem of nondeclarants.<sup>134</sup>

### *A. The Ohio Statute Runs Contrary to Public Opinions*

Unfortunately, the Ohio statute fails to accurately reflect the views of most individuals. Studies show that an overwhelming majority of people believe that decisions on whether to terminate life support systems, including artificial nutrition and hydration, belong with the family.<sup>135</sup> Indeed, this is not only the view of most citizens at large, but is also the view receiving widespread support from commentators as well.<sup>136</sup> Not only are family members most likely to know what the patient would have desired, but they are most likely to have the patient's best interests at heart. Also, the family members have the

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<sup>132</sup> See *Doe*, 583 N.E.2d at 1272-74 (Nolan, J., dissenting).

<sup>133</sup> Gold, *supra* note 20, at 1090-91.

<sup>134</sup> The Ohio statute in essence adopts a substituted judgment standard. Although this standard has been criticized for the reasons mentioned above, it is at least more appropriate for the legislature, rather than judges, to make the determination of what standard should be used.

<sup>135</sup> See Gasner, *supra* note 4, at 13-14. Gasner cites a 1986 poll by the American Medical Association in which 73% of the people responding thought that life support systems, including artificial nutrition and hydration, should be removed if the family requests the discontinuation of such treatment. Gasner also points to a poll conducted by Ted Koppel that shows that 70% feel that the family should decide whether life supports should be removed from permanently unconscious patients.

<sup>136</sup> See generally Gasner, *supra* note 4; Stephen A. Newman, *Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physician, and the State*, 3 N.Y.L. SCH. J. HUM. RTS. 35, 46 (1985); Rushton, *supra* note 129.

Also, the American Medical Association states that "if the patient is incompetent to act in his own behalf and did not previously indicate his preferences, the family or other surrogate decisionmaker, in concert with the physician, must act in the best interest." American Medical Association Council, *supra* note 104. This view is supported by the American Academy of Neurology as well. American Academy of Neurology, *supra* note 104.



most to suffer, emotionally and many times financially, from a permanently unconscious patient. Thus, it is eminently logical that the decision be given to the family immediately, and not taken out of their hands for over a year.

Further, a recent study shows that 85% of those surveyed indicated that they would not wish to be maintained through artificial nutrition and hydration if they fell permanently unconscious and could not eat on their own.<sup>137</sup> This statistic is especially unsettling when read in conjunction with the small number of people who will eventually implement advance directives. Given the small amount of people who will actually implement an advance directive, and the large number of people who do not wish to be artificially maintained, it seems apparent that the Ohio law will trample on the desires of the people it is supposed to protect.

### *B. The Ohio Statute Is Not Supported by Modern Medical Opinion*

Contrary to prevailing medical authority, the living will statute distinguishes between artificial nutrition and hydration and other means of life support. The statute demands that removal of artificial nutrition and hydration from a permanently unconscious person be approved by the probate court, which must withhold such permission if it finds that clear and convincing evidence does not exist showing that the patient would have wanted such removal.<sup>138</sup> This requirement, at the very least, delays the family's wishes by another one to two months after they have already waited one year to seek such removal. At the worst, it prevents families from carrying out their wishes altogether by empowering a judge to find that the clear and convincing evidence standard has not been met.

It could be claimed that death by the removal of nutrients is somehow more gruesome than death by the removal of other life support systems, and thus worthy of the extra protection. Although some commentators have described in unpleasant detail the process of dying by dehydration, such descriptions become meaningless when one realizes that permanently unconscious patients cannot suffer.<sup>139</sup> Indeed, the Ohio statute does not permit

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<sup>137</sup> See Gasner, *supra* note 4, at 14 (citing to a survey performed by the Colorado Graduate School of Public Affairs).

<sup>138</sup> See *supra* notes 59–60 and accompanying text.

<sup>139</sup> Death by the removal of artificial nutrition and hydration would take anywhere between one and thirty days. Although death by starvation or dehydration normally causes some extremely horrible side effects (dry mouth caked with thick material, swollen and cracked tongue, nose bleeds), most can be alleviated through good nursing care during the withdrawal period. Cranford, *supra* note 1, at 31. Further, none of the symptoms will be

the removal of artificial nutrients if a finding is made that the nutrients provide any comfort care to the patient.<sup>140</sup> Thus, once it is established that comfort care is not being provided by the nutrition and hydration, there remains absolutely no reason to distinguish between artificial nutrients and other measures of life support.

Also, the removal of artificial nutrition and hydration has been generally recognized by all the major medical organizations as no different than other forms of medical treatment.<sup>141</sup> This view is further reflected in Justice O'Connor's concurrence in *Cruzan*, in which she expressly rejects the distinction between artificial nutrition and hydration and other life support systems.<sup>142</sup> In fact, the majority opinion in *Cruzan* also implies that no distinction between the two methods of life support are justified, and thus it is possible that any constitutional arguments attempting to distinguish the two will not be successful.<sup>143</sup> Thus, the Ohio statute reflects an illogical and outdated opinion with regards to the termination of artificial nutrition and hydration.<sup>144</sup>

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experienced by the patient because, as stated before, the loss of the cerebral cortex precludes the PVS patient from experiencing any such sensations. *Id.*

<sup>140</sup> OHIO REV. CODE ANN. § 2133.09(A)(3) (Baldwin 1991).

<sup>141</sup> According to the American Academy of Neurology, "[t]he artificial provision of nutrition and hydration is a form of medical treatment analogous to other forms of life sustaining treatment . . . such as the use of the respirator." This is also the position taken by the American Medical Association. See *Cruzan v. Director Missouri Dep't of Health*, 497 U.S. 261, 308 (1990) (Brennan, J., dissenting) (citing to American Academy of Neurology, *supra* note 104; American Medical Association Council, AMA Ethical Opinion 2.20, *Withholding or Withdrawing Life-Prolonging Medical Treatment* in CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1989)).

<sup>142</sup> *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring) (citing American Medical Association Council, AMA Ethical Opinion 2.20, *Withholding or Withdrawing Life-Prolonging Medical Treatment*, in CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, Current Opinions 13 (1989); THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE SUSTAINING TREATMENT AND CARE OF THE DYING 59 (1987)).

<sup>143</sup> *Cruzan*, 497 U.S. at 273-75. Chief Justice Rehnquist cited the *Conroy* case for the proposition that artificial nutrition and hydration is no different than other forms of life-sustaining treatment, causing some commentators to believe the Court has adopted this approach. See Wayne Karbal, *The Constitutional Dimensions of the Right to Refuse Medically Assisted Nutrition and Hydration: An Analysis of Cruzan*, 23 J. HEALTH & HOSP. L. 241, 244 (1990).

<sup>144</sup> Indeed, the Ohio statute is truly a step backwards for protecting the right to refuse medical treatment when considered in light of the recent cases allowing termination of life support systems for the permanently unconscious. See, e.g., *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) (removal of feeding tube permitted); *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987) (en banc) (removal of feeding tube allowed); *McConnell v. Beverly*

The fact that PVS patients must wait one year before life support may be withdrawn also represents a misunderstanding of modern medical studies regarding patients in persistent vegetative states. Such patients, as noted before, have virtually no chance of recovery. Further, doctors, not lawyers, are in the best position to determine how long a patient must be in a PVS before the person's condition is hopeless.

In fact, recent medical studies show that there is no one set length of time that doctors should wait before finding that artificial life supports should be removed.<sup>145</sup> Instead, such determinations depend upon a variety of factors, including the age of the patient and the nature of the injury suffered. For example, a patient whose brain has suffered a severe deprivation of oxygen from asphyxial injuries or a cardiac arrest should probably be given only one month to come out of the PVS.<sup>146</sup> On the other hand, a doctor might recommend that a young patient who has suffered a head injury from a car accident should be given six months to a year to come out of the vegetative state.<sup>147</sup> Because older people have less chance of recovery than younger individuals, the current medical view also supports a shorter or longer wait depending upon the age of the victim.<sup>148</sup> Thus, the twelve month wait is a largely arbitrary length of time, and is unsupported by contemporary medical literature.

## VII. CONCLUSION

Ohio's living will statute goes a long way in solving some of the difficult problems raised by today's medical technology. It provides individuals with a convenient way to express their desires concerning life-sustaining treatment should they become terminally ill or in a persistent vegetative state.

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*Enterprises-Connecticut, Inc.*, 553 A.2d 596 (Conn. 1989) (removal of gastronomy tube allowed pursuant to a statute when patient had previously expressed wishes concerning life-sustaining treatment); *Corbett v. D'Allessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986) (removal of feeding tube permitted from PVS patient); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989) (authorizing removal of gastronomy tube); *In re Gardner*, 534 A.2d 947 (Me. 1987) (life-sustaining procedures removed from patient in PVS); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626 (Mass. 1986) (feeding tube removed from PVS patient); *In re Torres*, 357 N.W.2d 332 (Minn. 1984) (allowing permanently unconscious patient to be removed from life support systems); *In re Peter*, 529 A.2d 419 (N.J. 1987) (treatment discontinued in elderly PVS patient); *In re Jobes*, 529 A.2d 434 (N.J. 1987) (removal of life supports from PVS patient permitted).

<sup>145</sup> Council Report, *supra* note 18, at 427-28.

<sup>146</sup> *Id.* at 427.

<sup>147</sup> *Id.* at 428.

<sup>148</sup> *Id.* at 427-28.

However, the statute fails in its attempt to adequately provide for nondeclarants. It is underprotective of an individual's constitutional rights for those people that find themselves in a permanently unconscious state without an advance directive. The statute refuses to recognize that people without advance directives also have a constitutional right to decline medical treatment once their desire to do so has been proven, as mandated by the *Cruzan* decision. This right cannot arbitrarily be taken away without an overriding state interest, and because none exists, the state's mandate that such individuals wait a year before the removal of artificial nutrition and hydration violates their rights under the Constitution.

The practical implications, as opposed to merely the constitutional implications, are unsettling as well. The statute shuts its eyes to the reality that human beings, by nature, do not like to think about their own death, and will not plan ahead for the possible tragedy of entering a permanently vegetative state. It also ignores modern medical opinions regarding PVS patients, and the beliefs of the constituents the statute was designed to protect. Thus, the Ohio legislature should rethink its most recent attempt to deal with the right to die issue, and come up with a solution that will put such difficult decisions back in the hands of the families, where they rightfully belong.

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